ASSEMBLY BILL No. 598

Introduced by Assembly Member De La Torre

February 17, 2005

An act to add Section 511.4 to the Business and Professions Code, to amend Sections 1367 and 1375.7 of the Health and Safety Code, and to amend Sections 10133.5 and 10133.65 of the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 598, as introduced, De La Torre. Health care contracts.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

This bill would require all contracts between a health care provider and a contracting agent, as defined, to be fair and reasonable. The bill would also require all contracts, including contracts with health care providers and other persons furnishing services and facilities, and a health insurer, to be fair and reasonable.

This bill would, except as specified, require all contracts between health care service plans or health insurers and health care providers to be renewed and approved by the Department of Managed Health Care or the Commissioner of the Department of Insurance prior to being offered to the provider.

The bill would prohibit a contract from containing a provision that waives a provider's right to resolve disputes on a class basis where the law would have authorized that resolution. The bill would require a contract issued, amended, or renewed between a health care service

plan or health insurer and a health care provider to have renewal contingent on the provider's annual execution. The bill would make related changes.

Because a willful violation of the bill relating to health care service plans would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares as follows:

(a) Individuals enrolled in health care service plans regulated by the Department of Managed Health Care or health insurance policies regulated by the Department of Insurance are entitled by law to receive accessible quality health and medical services.

(b) To ensure access to care, health care service plans and health insurers are required to have an adequate network of contracting health care providers. Those contracts by law must be fair.

(c) Unfortunately, there are increasing signs that access to care in California is not being achieved. Providers are increasingly unable to participate in managed care contracts because many times, the contract terms are unfair and in some cases, illegal.

(d) More protections need to be in place to ensure fair contracting so that more providers will participate in managed care plans and patients will have increased access to care.

SEC. 2. Section 511.4 is added to the Business and Professions Code, to read:

511.4. (a) All contracts between a health care provider and contracting agent, as defined in paragraph (2) of subdivision (d) of Section 511.1, shall be fair and reasonable.

(b) A contract issued, amended, or renewed on or after January 1, 2006, between a contracting agent and a health care provider

for the provision of health care services shall not contain any of the following terms:

(1) (A) Authority for the contracting agent to change a material term of a manual, policy, or procedure document referenced in the contract, unless the contracting agent provides 45 business days' notice to the provider, and the provider has the right to negotiate and agree to the change. If the contracting agent and the provider cannot agree to the change to a manual, policy, or procedure document, the provider has the right to terminate the contract prior to the implementation of the change. In any event, the contracting agent shall provide at least 45 business days' notice of its intent to change a material term, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. However, if the parties mutually agree, the 45-business day notice requirement may be waived. Nothing in this subparagraph limits the ability of the parties to mutually agree to the proposed change at any time after the provider has received notice of the proposed change.

(B) If a contract between a provider and a contracting agent is for the provision of benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting a material change to the contract by the contracting agent if the contracting agent provides at least 45 business days' notice to the provider of the change and the provider has the right to terminate the contract prior to the implementation of the change.

(2) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(3) A requirement to comply with any quality improvement or utilization management programs or procedures of a contracting agent, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the contracting agent may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply

with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to paragraph (1).

(4) A provision that waives or conflicts with any provision of the Health and Safety Code or the Insurance Code.

(5) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(6) A provision that requires providers to waive their rights to resolve disputes on a class basis where the law otherwise would have authorized such resolution in the absence of any contractual agreement.

(c) Effective January 1, 2006, a contract issued, amended, or renewed between a contracting agent and a health care provider for the provision of health care services shall do the following:

(1) Have renewal be contingent on the provider's annual execution.

(2) Specify clearly in the text of the contract all amendments made from the prior year's version, where a prior contract exists.

(3) Contain model language adopted through regulations by the Department of Insurance and Department of Managed Health Care apprising providers of their contracting and payment rights under the law.

(d) Any contract provision that violates subdivision (a), (b), or (c) shall be void, unlawful, and unenforceable.

(e) For purposes of this section the following definitions apply:

(1) "Health care provider" means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

(2) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision. Notice of a material change shall be accomplished by registered or certified mail to the provider.

SEC. 3. Section 1367 of the Health and Safety Code is amended to read:

1367. A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

(a) Facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) Personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

(c) Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e) (1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

(2) To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.

(3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) (1) Contracts with subscribers and enrollees, including group contracts, and contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted. *Effective January 1, 2006, unless individually negotiated, all contracts with providers shall be reviewed and approved by the department prior to the contract being offered to providers. For the purposes of this section, "individually negotiated" means a contract pursuant to which the parties to the contract, as a result of negotiation, agreed to substantial modifications to the nonpayment terms of a plan's standard form agreement to individually suit the needs of a contracting provider group.*

(2) A health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(3) On and after January 1, 2002, a health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.

(i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations

on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(j) A health care service plan shall not require registration under the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.

The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

SEC. 4. Section 1375.7 of the Health and Safety Code is amended to read:

1375.7. (a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.

(b) No contract issued, amended, or renewed on or after January 1, 2003, between a plan and a health care provider for the provision of health care services to a plan enrollee or subscriber shall contain any of the following terms:

(1) (A) Authority for the plan to change a material term of the contract, unless the change has first been negotiated and agreed to by the provider and the plan or the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. If a change is made by amending a manual, policy, or procedure document referenced in the contract, the plan shall provide 45 business days' notice to the provider, and the provider has the right to negotiate and agree to the change. If the plan and the provider cannot agree to the change to a manual, policy, or procedure document, the provider has the right to terminate the contract prior to the implementation of the change. In any event,

the plan shall provide at least 45 business days' notice of its intent to change a material term, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. However, if the parties mutually agree, the 45-business day notice requirement may be waived. Nothing in this subparagraph limits the ability of the parties to mutually agree to the proposed change at any time after the provider has received notice of the proposed change.

(B) If a contract between a provider and a plan provides benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting a material change to the contract by the plan if the plan provides at least 45 business days' notice to the provider of the change and the provider has the right to terminate the contract prior to the implementation of the change.

(C) If a contract between a noninstitutional provider and a plan provides benefits to enrollees or subscribers covered under the Medi-Cal or Healthy Families program and compensates the provider on a fee-for-service basis, the contract may contain provisions permitting a material change to the contract by the plan, if the following requirements are met:

(i) The plan gives the provider a minimum of 90 business days' notice of its intent to change a material term of the contract.

(ii) The plan clearly gives the provider the right to exercise his or her intent to negotiate and agree to the change within 30 business days of the provider's receipt of the notice described in clause (i).

(iii) The plan clearly gives the provider the right to terminate the contract within 90 business days from the date of the provider's receipt of the notice described in clause (i) if the provider does not exercise the right to negotiate the change or no agreement is reached, as described in clause (ii).

(iv) The material change becomes effective 90 business days from the date of the notice described in clause (i) if the provider does not exercise his or her right to negotiate the change, as described in clause (ii), or to terminate the contract, as described in clause (iii).

(2) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(3) A requirement to comply with quality improvement or utilization management programs or procedures of a plan, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the plan may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to paragraph (1).

(4) A provision that waives or conflicts with any provision of this chapter. A provision in the contract that allows the plan to provide professional liability or other coverage or to assume the cost of defending the provider in an action relating to professional liability or other action is not in conflict with, or in violation of, this chapter.

(5) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(6) A provision that requires providers to waive their rights to resolve disputes on a class basis where the law otherwise would have authorized that resolution in the absence of a contractual agreement.

(c) (1) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(2) For purposes of this subdivision, the following terms shall have the following meanings:

(A) "Contracting agent" has the meaning set forth in paragraph (2) of subdivision (d) of Section 1395.6.

(B) "Payor" has the meaning set forth in paragraph (3) of subdivision (d) of Section 1395.6.

(d) *Effective January 1, 2006, every contract issued, amended, or renewed between a plan and a health care provider for the provision of health care services to a plan enrollee or subscriber shall do all of the following:*

(1) Have renewal be contingent on the provider's annual execution.

(2) Specify clearly in the text of the contract all amendments made from the prior year's version, where a prior contract exists.

(3) Contain model language adopted by the department through regulations apprising providers of their contracting and payment rights under this chapter.

(e) Any contract provision that violates subdivision (b) ~~or (c)~~*, (c), or (d)* shall be void, unlawful, and unenforceable.

~~(e)~~

(f) The department shall compile the information submitted by plans pursuant to subdivision (h) of Section 1367 into a report and submit the report to the Governor and the Legislature by March 15 of each calendar year.

~~(f)~~

(g) Nothing in this section shall be construed or applied as setting the rate of payment to be included in contracts between plans and health care providers.

~~(g)~~

(h) For purposes of this section the following definitions apply:

(1) "Health care provider" means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

(2) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision. *Notice of a material change shall be accomplished by registered or certified mail to the provider.*

SEC. 5. Section 10133.5 of the Insurance Code is amended to read:

10133.5. (a) The commissioner shall, on or before January 1, 2004, promulgate regulations applicable to health insurers which contract with providers for alternative rates pursuant to Section

10133 to ensure that insureds have the opportunity to access needed health care services in a timely manner. *To accomplish this goal, all contracts, including contracts with providers and other persons furnishing services or facilities, shall be fair and reasonable. Effective January 1, 2006, unless individually negotiated, all contracts with providers shall be reviewed and approved by the commissioner prior to the contract being offered to providers. For purposes of this section, "individually negotiated" means a contract pursuant to which the parties to the contract, as a result of negotiation, agreed to substantial modifications to the terms of a insurer's standard form agreement to individually suit the needs of a contracting provider.*

(b) These regulations shall be designed to assure accessibility of provider services in a timely manner to individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract. The regulations shall insure:

1. Adequacy of number and locations of institutional facilities and professional providers, and consultants in relationship to the size and location of the insured group and that the services offered are available at reasonable times.

2. Adequacy of number of professional providers, and license classifications of such providers, in relationship to the projected demands for services covered under the group policy or plan. The department shall consider the nature of the specialty in determining the adequacy of professional providers.

3. The policy or contract is not inconsistent with standards of good health care and clinically appropriate care.

~~4. All contracts including contracts with providers, and other persons furnishing services, or facilities shall be fair and reasonable.~~

(c) In developing standards under subdivision (a), the department shall also consider requirements under federal law; requirements under other state programs and law, including utilization review; and standards adopted by other states, national accrediting organizations and professional associations. The department shall further consider the accessability to provider services in rural areas.

(d) In designing the regulations the commissioner shall consider the regulations in Title 28, of the California

Administrative Code of Regulations, commencing with Section 1300.67.2, which are applicable to Knox-Keene plans, and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost efficient system of indemnification. The department shall consult with the Department of Managed Health Care concerning regulations developed by that department pursuant to Section 1367.03 of the Health and Safety Code and shall seek public input from a wide range of interested parties.

(e) Health insurers that contract for alternative rates of payment with providers shall report annually on complaints received by the insurer regarding timely access to care. The department shall review these complaints and any complaints received by the department regarding timeliness of care and shall make public this information.

(f) The department shall report to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature on March 1, 2003, and on March 1, 2004, regarding the progress towards the implementation of this section.

(g) Every three years, the commissioner shall review the latest version of the regulations adopted pursuant to subdivision (a) and shall determine if the regulations should be updated to further the intent of this section.

SEC. 6. Section 10133.65 of the Insurance Code is amended to read:

10133.65. (a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.

(b) No contract issued, amended, or renewed on or after January 1, 2003, between a health insurer and a health care provider for the provision of covered benefits at alternative rates of payment to an insured shall contain any of the following terms:

(1) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(2) A requirement to comply with quality improvement or utilization management programs or procedures of a health insurer, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider

executing the contract. However, the health insurer may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to subdivision (c).

(3) A provision that waives or conflicts with any provision of the Insurance Code.

(4) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(5) A provision that requires providers to waive their rights to resolve disputes on a class basis where the law otherwise would have authorized that resolution in the absence of a contractual agreement.

(c) If a contract is with a health insurer that negotiates and arranges for alternative rates of payment with the provider to provide benefits to insureds, the contract may contain provisions permitting a material change to the contract by the health insurer if the health insurer provides at least 45 business days' notice to the provider of the change, and the provider has the right to terminate the contract prior to implementation of the change.

(d) *Effective January 1, 2006, every contract issued, amended, or renewed between a health insurer and a health care provider for the provision of health care services to an insured shall do all of the following:*

(1) Have renewal be contingent on the provider's annual execution.

(2) Specify clearly in the text of the contract all amendments made from the prior year's version, where a prior contract exists.

(3) Contain model language adopted by the commissioner through regulations apprising providers of their contracting and payment rights under this chapter.

(e) Any contract provision that violates subdivision (b) ~~or (c)~~*, (c), or (d)* shall be void, unlawful, and unenforceable.

~~(c)~~

(f) The Department of Insurance shall annually compile all provider complaints that it receives under this section, and shall report to the Legislature and the Governor the number and nature of those complaints by March 15 of each calendar year.

~~(f)~~

(g) Nothing in this section shall be construed or applied as setting the rate of payment to be included in contracts between health insurers and health care providers.

~~(g)~~

(h) For purposes of this section, the following definitions apply:

(1) "Health care provider" means any professional person, medical group, independent practice association, organization, health facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services.

(2) "Health insurer" means any admitted insurer writing health insurance, as defined in Section 106, that enters into a contract with a provider to provide covered benefits at alternative rates of payment.

(3) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision. *Notice of a material change shall be accomplished by registered or certified mail to the provider.*

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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